Wright's Law

TO THE EDITOR: After 40 years of research, Edwin S. Wright, MD, has evolved a new economic theory of world-shaking importance. It is called Wright's theory of economic determinism. Its author modestly believes the theory will place him in history beside Karl Marx (theory of dialectical materialism) and Adam Smith *(Wealth of Nations)*. Probably a Nobel Prize will result.

The theory of economic determinism is elegantly simple. It says, "in any situation, the economics determine the action." A few simple examples follow.

Example 1. A glaucoma patient no longer responds to medication and the clinician must now choose surgical treatment. Should he or she use laser trabeculoplasty or surgical trabeculectomy? With laser treatment, reduced intraocular tension lasts 4 to 12 months and then it returns to prelaser levels. Surgical trabeculectomy is effective immediately in 95% of cases. The clinician employs Wright's theory of economic determinism and the choice is immediately clear. It is better to get paid for two operations rather than one, so the clinician does the laser treatment first and then the trabeculectomy.

Example 2. The green traffic light comes on and A drives through the intersection but, seeing a gorgeous girl in a mini skirt, he suddenly stops. B driving behind A can't stop in time and hits A's car, though rather lightly. A and B get out of their cars and survey the damage, which is negligible. They proceed on their way but A's wife comments on what an imbecile he is and he ought to sue. A consults his lawyer as to whether or not he was grievously damaged. They now apply Wright's law. Of course he was damaged so they sue for $250,000 and the insurance company settles for $18,000. A and his lawyer are happy by virtue of Wright's law.

Example 3. Government officials desire to aid the Contras but not enough money is given by Congress. How can the financial status of the Contras be improved? They apply Wright's law and at once the problem is solved. Sell arms to eager but illegal customers and divert the profits to those whom the officials believe are deserving recipients.

The three examples are only a few of the universal applications of the law. Wright modestly believes that application of his law will quickly solve most of life's problems.

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Dollar Mentality

TO THE EDITOR: Dollar Mentality[1] is a MAD (Medical Anonymity Disorder) caused by deficiency of DPR (the Doctor-Patient Relationship). He who pays the piper calls the tune, so those RAPS (Radiologists, Anesthesiologists, Pathologists and Surgeons) who sold their souls to the BRP (Bureaucracy, Regulators and Politicians, pronounced BuRP) in the high-pay HIC (Hospital-Insurance Complex, pronounced as in HICcup) will be the first to hear the DRG (Diagnostic-Related Group, pronounced DiRGe).

Other susceptibles include cardiologists and gastroenterologists who split fees with hospitals by doing procedures there like colonoscopy, which I do in my office on everyone over age 40, every five years, "regardless of ability to pay" (dusty motto of the Alameda-Contra Costa Medical Association). My treatment for MAD also includes the acceptance of Medi-Cal patients—but not Medi-Cal payments (which hardly cover the cost of the red tape). I won't feed its BRP and HIC.

The third symptom of this MAD is CHRN (Colleague High Referral Number, pronounced CHuRN). A patient with irritable bowel, dyspareunia, palpitations, pyorrhea and back pain may be CHRNed among five specialists more concerned with BRP, HIC and the dollar than the patient.

Treatment for MAD is DPR, referring not only to the Doctor-Patient Relationship, but also to its natural outgrowth, Doctor-Patient Responsibility (a two-way street). One cannot give health, it must be *earned*. We should contract with patients and their employers for SINE: Smokeless, Sober, Safety-belted; Interviewed, Inspected and Informed yearly, for Naturalized, Neutralized and Normalized *lifestyles*—Entrusted, Enriched and Enlivened with employer trust accounts ("Health Pay"), instead of premiums.

DPR can grow SINE now, independent of BRP, HIC and CHRN. I believe it can cure the dollar mentality and eliminate 70% of the cost. How else empower "the judgment of the person receiving care,"—Bristow's "Aim for American Medicine"?[2]

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Cultural Change, Social Disintegration and Medicine

TO THE EDITOR: Your editorial "Health Care in a Dreamworld" in the April issue[1] articulates the growing serious loss of élan and sense of purpose in the medical profession as it sees the substance of medicine: medical diagnosis and treatment, being eroded and destabilized. Meanwhile, the institutionalization of the process, "health care" goes merrily on its way when everyone becomes the "provider" but assumes little if any responsibility for the outcome except the physician.

There is no way out of the morass, it seems to me, but to define the terms of the controversy. To persist in accepting the role of "health care provider" and negotiate with "health care insurers" is untenable. All we can provide is medical diagnosis and treatment.

To continue on under the paradigm of "health care" as our industry and business is to guarantee system failure both in cost allocation and patient satisfaction.

The results of cultural change and social disintegration are translated at end-point to health care. Social remediation costs need to be separated from medical diagnosis, treatment and medical prevention (for example, immunization). To continue to accept a role of providing "health" and be held responsible for all the resulting costs is to accept progressive cutting of money for the care of the sick and disabled as has happened with Medi-Cal. We can continue to expect a proliferation of all sorts of complex and tenuous schemes to control costs while restricting freedom of both the patient and the physician. We can ultimately expect the physician to shift responsibility to the state in order to cope: "I was just following

orders." Unless we can define the terms, we physicians will continue to be the scapegoats for the costs of serious underlying structural problems in the society under the rubric of "health care provider."

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Importance of Dive Tables in Scuba Diving

TO THE EDITOR: As a scuba divemaster and a physician I am responding to the letters from Robert Fritz[1] and Dr Greenhouse[2] in the March 1987 issue.

I agree the case presented of meralgia paresthetica[3] is most likely due to weight belt compression, but do wish to comment on Dr Greenhouse's statement that the dives were made at sea level by a person very experienced in the sport who took all recommended precautions.

A competent and experienced diver makes every dive a no-decompression dive. The maximum time limit at 80 feet is 40 minutes. A 50-minute dive would require a 10-minute decompression stop at 10 feet, as stated by Mr Fritz.

Scuba diving is a challenging and fun sport, but also one in which life-threatening complications can occur if divers are careless in their regard for the dive tables.

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